

APPLICATION FOR LICENSE TO OPERATE A FAMILY CARE HOME

I. IDENTIFICATION

Name of Operators: _____

Address: _____
(Street)

(City) (State) (Zip)

County: _____

Phone Number: _____
(Area Code) (Number)

II. Name and address of person who _____
operates home during any absence (Name)
of the licensed operator:

(Street)

(City) (State) (Zip)

III. Date home began operation at present address: _____

IV. Number of years of education of operator: _____

V. Is/are person(s) operating this home employed outside the home: _____

If the answer is yes, explain: _____

VI. Have you been convicted of violation of any law within the past five (5) years? If yes, explain:

VII. Licensed capacity requested: Two () Three ()

VIII. Name of persons who reside in this home:

<u>Name</u>	<u>Age</u>	<u>Family Member</u>		<u>Patient</u>		<u>Other</u>
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	
		Yes	No	Yes	No	

- IX. I agree that this home and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personal.
- X. I have not had a license to operate any facility or service suspended or revoked during the three (3) years immediately preceding this application.
- XI. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial of licensure.

Signature(s) of Operator(s)

(Date)

- XII. License fee: \$40.00

**MAKE CHECK OR MONEY ORDER PAYABLE TO
KENTUCKY STATE TREASURER.
THIS FEE IS NON-REFUNDABLE
DO NOT SEND CASH.**

Please return completed from to:

Division of Long Term Care
275 East Main Street 5E-A
Frankfort, Kentucky 40621

TO BE COMPLETED BY DIVISION OF LONG TERM CARE ONLY:

Date Received: _____
Amount: _____